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ABSTRACT

The paper describes the proposed Upper Cumberland Early Intervention Project (UCEIP), a project designed to serve 20 handicapped preschoolers a year over a 3 year period in rural Tennessee. The project involves continuation and expansion of two service delivery models for rural areas and is funded under the Developmental Disability Services Act, 1978. One of the two centers will utilize the Regional Intervention Program for Preschoolers and Parents model which is designed to provide short term (mean length of treatment 8 months) intervention assistance as an alternative to residential programs, and upon termination, to seek the least restrictive learning environment appropriate for the child. Characteristics of the model include parent implementation first with their own children and then in training other parents, modular organization, daily monitoring of child and parent performance, and a resource staff of professional consultants. The other center all utilize the Family, Infant and Toddler Project: Early Intervention with Rural Families with Retarded Children model. The model involves weekly training sessions with children and families who are trained to implement an educational program at home. Short range goals and objectives are set for implementation during a 3 month period of observation and discussion with parents at which time long term educational goals are established in the following domains: gross motor development, personal social skills, hearing and speech skills, nonverbal communications, eye-hand coordination skills, manipulation skills, cognition skills, and verbal and gestural imitation skills. Both models were originally funded through the Handicapped Children's Early Education Program and UCEIP will provide temporary funding while local funding, administrative, and transportation procedures are being established. (DB)

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MODEL PRESCHOOL PROGRAMS IN A RURAL SETTING: TOWARD A SERVICE CONTINUUM

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Introduction

The purpose of this paper is to describe the development, implementation, and operation of a service program for developmentally disabled preschoolers (birth to age 4) in the 14 county, Upper Cumberland District of Middle Tennessee. This District typifies many of the problems associated with rural Appalachia. Nine of the 14 counties, designated by EDA as Redevelopmental Areas, had unemployment rates up to 13.7 percent and average incomes ranging from about one-half to three-fourths of the state average and about one-half of the national average. The remaining five counties were classified as Developmental Areas. Within the District are found five of the 100 most disadvantaged rural counties in America. The population of the UCDD decreased during the period 1940 to 1960, as a result of out-migration. During the period of 1960 to 1970, a district-wide population gain of 5.4 percent occurred, but 12 of the 14 counties still had losses from out-migration. There has also been a gain in population during the 1970-80 decade. Historically, most out-migrates have been young adults and those with above average education.

Almost 40 percent of the residents of the UCDD live on farms. In 1970, 37.7 percent of the District households had a total annual income below $3,000 compared with 25.2 percent for Tennessee and 16.9 percent

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for the entire nation. Fifty-nine percent of the households had annual incomes of less than $5,000. The per capita personal income for the District in 1979 was $4,935, compared to per capita personal income of $6,561 for Tennessee and $7,840 for the United States.

The major social problem facing the District is the poor quality of education; the major economic problem is the lack of job opportunities. Each of these problems helps perpetuate the other. Education, either the cause of other District problems or the result of them, is inadequate. School drop-outs continue to be a severe District-wide problem.

In the Summer of 1980 a grant from the State Developmental Disabilities Council was received to fund a project designed to foster continuation, expansion and coordination of services to preschool, exceptional children and their parents in this rural and disadvantaged region of Tennessee. This Project, entitled the Upper Cumberland Early Intervention Project (UCEIP), is designed to serve 20 handicapped preschoolers each year, over a three-year period. Historically, geographic regions like the Upper Cumberland have been dependent on sources outside the region for the initiation of most special programs, including services to handicapped preschoolers. Most often these programs have taken the form of federally-funded model projects granted to agencies in metropolitan areas; in turn these agencies provide outreach programs to rural communities. In this instance, the State University in the Upper Cumberland District, Tennessee Technological University, initiated efforts to secure funds from DDSA (Developmental Disability Services Act, 1978) to continue and expand two of these models designed as outreach programs to rural areas. The service delivery models are described in some detail below and issues related to

their continuation, following the termination of federal and state developmental disabilities funds are discussed.

Service Delivery

The plans and approach for two service components are described below, including centers in two communities, Cookeville and McMinnville. Prior to presenting that information something should be said about the projected plans for a three-year project period and the approach to be applied. As noted earlier the mission of this project is to generate, develop, expand and support services for developmentally delayed preschool children in all of the Upper Cumberland 14 counties. It is clear from 1980 census data and in incidence figures that there are and will be many more children in need of early intervention than the 20 who will be served through the project activities at Cookeville and McMinnville.

For some families, especially in the outlying counties, travel into one of the centers is impractical. A study of needs of these isolated communities and families will be ongoing as a part of the project and communities will be assisted as the need arises in making plans for services and identifying local funds for starting and maintaining services. From the outset the approach of the Upper Cumberland Early Intervention Project has been to foster awareness of the need for preschool intervention and to assist communities, counties and county clusters in developing and assuming local control and responsibility for helping delayed preschoolers and their families.

THE "RIP" MODEL

The Regional Intervention Program for Preschoolers and Parents, more commonly referred to as RIP was founded in September 1969, at the John F. Kennedy Center, George Peabody College, Nashville, Tennessee. Original funding was provided by the Bureau of Education for the Handicapped, Handicapped Children's Early Education Program (HCEEP, 1968). Since June 1972, RIP has been sponsored by the Tennessee Department of Mental Health and Mental Retardation, first directly under the Children and Youth Services Section of the central office and later in 1973 transferring sponsorship to Middle Tennessee Mental Health Institute, Children and Youth Services.

RIP provides services for families of handicapped children under five years of age. The RIP model is designed to provide relatively short-term intervention assistance to participating families as an alternative to residential programs, and upon termination, to seek the least restrictive learning environment appropriate for the child. Because of the program's noncategorical policy, RIP has served children with wide variety of handicapping conditions and exceptionalities. These would include, but would not be limited to: cerebral palsy, brain damage, speech, hearing and language impairments, behavior disorders, emotional disturbances, autism, Down's Syndrome and a number of other syndromes associated with chromosomal anomalies.

There is no fee for families who receive RIP services. Instead, a parent, usually the mother, participates with her child and with other families five mornings a week during the active treatment period. After work with her own child has been completed, the parent participates in a six month "payback" period to provide assistance, support and training

to newly enrolled families. As there is no waiting list, the family begins treatment soon after referral and the average length of treatment is eight months.

RIP is organized on a modular basis. Each direct service module is coordinated by a trained parent who provides systematic training for each new family entering the program. Child programs and parent performance are monitored daily by direct observational data systems and evaluated every six weeks through analysis of family objectives. Five master's level professionals, called resource staff members, serve as middle managers of the overall RIP system. Responsibility for objectives, operations, and outputs of all RIP modules rests with resource staff members. Major modules include: Referral and Intake, Administration, Individual Tutoring, Generalization Training, Media, Theory Training, Liaison, Visitation, and External Training. The entire RIP system is guided by a management-by-objectives approach at the modular and individual family levels.

A network of professional consultants is available to back up the resource staff. Ongoing consultative input is provided by a pediatrician, a child psychiatrist, a family clinical psychologist, a child development specialist, a special educator and a speech pathologist/language development specialist. Also, to ensure that services meet high standards, a nine member Evaluation Committee meets monthly to review selected treatment and program operations data. The Evaluation Committee is composed of six former RIP parents who in turn select three additional members from the community.

During the first nine years of operation, RIP has served approximately 425 families. The average RIP child is 32 months old, 70% are male and 15% are from minority groups. RIP is available to persons in the 26 county

catchment area of the Middle Tennessee Mental Health Institute, with more than 25% of the families driving 50 miles or more per day (round trip). During its nine years of operation, RIP has become a nationally recognized program whose services delivery system has provided a model to many other special preschoolers within and outside the state of Tennessee. RIP has been the subject of numerous presentations at national professional meetings, and much research is housed at RIP as well, contributing greatly to the scientific knowledge base which guides programming for its target populations.

As a result of RIP's successful history, on February 28, 1974, the General Assembly of the State of Tennessee adopted House Resolution 109 which instructed the Commission of Mental Health and Mental Retardation to prepare a comprehensive plan for the statewide expansion of the Regional Intervention Program. Since 1975, the effort has been known as the RIP Expansion Project and is the official training and replication component of the RIP system.

The UCEIP: Cookeville Center is a certified RIP Replication Program and is guided substantially by this nationally-validated model for early intervention. Parent implementation is the most important and unique aspect of the model. The activities require that one parent or other primary caretaker be available to bring, stay with and learn the skills that are necessary to work with his or her own child while enrolled in the program. Program operations in the Cookeville Center are managed by a small Resource Staff. In addition to a resource person, the Principal assumes primary administrative and treatment responsibility for the day-to-day operations of the program, conducts public relations

activities, is responsible for referral, intake and followup and serves as a "back-up" to the resource staff.

A total of 12 developmentally disabled project-eligible children and their families will be served during the first year of the Project in the Cookeville Center. Additionally, approximately three preschool handicapped children (0-5 years) with primary behavior disorders will be included in the Project. These children, however, will not be served through the use of grant funds. Parent volunteers, graduate students and undergraduate practicum students will be involved to provide up to 6 hours a week of intervention for these children. Inclusion of these children is seen as a definite advantage for the Project since they will increase potential for group interaction and parent training.

The "FIT" Model

The Family, Infant and Toddler Project (FIT): Early Intervention for Rural Families with Retarded Children has been described in some detail (Gabel, 1979) by its developer Dr. Harris Gabel. Like the RIP model, it is a service delivery system which originated from a Bureau of Education for the Handicapped HCEEP grant, with matching funds from the Tennessee Department of Mental Health and Mental Retardation. The UCEIP: McMinnville Center is a one morning per week clinic which applies the FIT Model on behalf of seven (7) developmentally disabled preschoolers and their families.

An initial habilitation plan is designed for each child following his/her acceptance into the program. This plan is developed following administration of the Griffiths Scales of the measure developed by Uzgiris and Hunt (1975), informal clinical observation procedures to assess each child's current level of functioning in the intervention domains specified

below, and a family evaluation consisting of interviews with parents and other members and observations of family in interaction during the evaluation process. The family evaluations include a developmental history of the child, a description of the child's current level of functioning from the family's point of view, family expectations for the child, and the description of the overall current family situation.

The plan emphasizes short-range goals and objectives and calls for a three month period of observation and discussion with parents before long-term educational goals are established. These goals are set using input from both parents' and teachers' observations.

The habilitation program will consist of weekly educational clinic sessions with children and families. In these sessions, family members will be trained to implement an educational program at home with their children. The parents are viewed as the primary educational change agents, with the program providing skills, guidance and support. The educational program consists of the elements described in the following paragraphs.

The eight intervention domains in a FIT Program are (a) Gross Motor Development; (b) Personal-social Skills; (c) Hearing and Speech Skills; (d) Non-verbal Communications; (e) Eye-hand Coordination Skills; (f) Manipulation Skills; (g) Cognition Skills; (h) Verbal and Gestural Imitation Skills. Each of these domains parallel branches of development as described by Griffith (1968) and Uzgiris and Hunt (1975).

The schedule for the UCEIP: McMinnville Center FIT clinic is as follows: The educational clinic begins with a period of informal greeting and discussion when families first arrive for the clinic between 9:00 and 9:20. During the arrival period, the parents and teachers have the

opportunity to talk to each other, exchange information about the events of the last week, especially childrens' progress and generally share information parents consider personally meaningful. Parents converse among themselves during this period, providing additional peer support.

The arrival period is followed, at 9:20, by a group parent-child training session. This period consists of group songs and activities. A natural continuation of the arrival time, this first group activity offers additional opportunities for parents to demonstrate the accomplishments of their children and to compliment each other on these achievements.

The individualized parent-child training sessions consist of a teacher demonstrating and explaining intervention activities for parents and observing them implement activities with their children. Some parents will be grouped into groups of two for this aspect of the program when the same activity is appropriate for more than one child. This activity includes all teachers, parents and children. It is used for self-help training, social interaction skills, language intervention, and any other appropriate interventions. The parents will be present so that specific techniques can be taught and practiced, helping assure that they are used at home. This period also offers another natural opportunity for parents to raise and discuss issues about their children with the staff and other parents.

At 10:30, a second series of individualized parent-child training and parent implemented activities session are scheduled. Between 11:00 and 12:00, parents meet together for a parent group while children are gathered for a children's group.

Issues and Discussion

It has been pointed out (Swan, 1980) that demonstration projects funded by the Handicapped Children's Early Education Program, such as the two models described above, have been very successful in maintaining continuation funding for direct service components. The purpose of the UCEIP is to provide, through funds from the Developmental Disabilities Services Act, continuation of these two service delivery models for three years beyond the time provided through HCEEP demonstration or outreach grants. While both models clearly demonstrated that they were effective with young handicapped children and their families in the Upper Cumberland District, the extended funding period affords an intermediate step in securing long-term, local funding to continue and expand both service models. Several critical issues are being addressed in the UCEIP specific to fostering local commitment to service continuation, including program "ownership", demographic characteristics and Appalachian family lifestyles. The small communities and towns in the Upper Cumberland are much more supportive of services programs which they view as integral parts of their locale, staffed by local people and housed in community buildings, for example churches. Of special significance is the manner in which program budgeting decisions are made. Involvement of consumers, local agency representative and others from the community in planning the budget, and soliciting their input on expenditures is helpful.

A second issue relates to the problem of sparse population and distance between centers of population. Presently many of the families in the UCEIP travel between 60-100 miles round-trip each day to attend the Center programs. The Project is able to pay half of these expenses, and SSI elgible families may receive reimbursement for travel. It however seems likely that, when local monies take over the service components at the end of the three-year

period, transportation funds for most families will not be available. Both service delivery models in the UCEIP have as core components the training of parents whose skills will generalize to home and community settings. It is hoped that, at the end of the Project period, there will be a cadre of well-trained and committed parents who will take with assistance from professionals, substantial responsibility for development and implementation of services to preschool, exceptional children in rural, isolated communities.

Finally, the UCEIP is working toward refining the service models and establishing a continum of services for handicapped preschoolers which acknowledges and values the unique characteristics of many rural inhabitants of the Upper Cumberland. It has been noted that these characteristics include a somewhat passive and fatalistic view of the world, a lack of future orientation, suspicious of outsiders, including agencies, and a strong emphasis on family and family centered needs. These factors provide both a challenge and an opportunity for our Project to adapt and expand the service delivery models to reach a much greater number of young children with special needs.

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